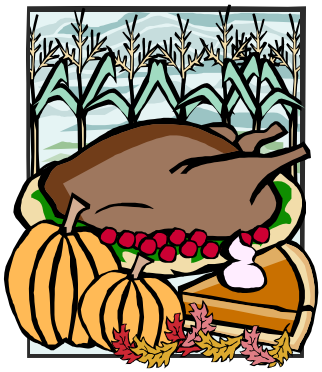
REGION VII AGING SERVICES

Cherry Schmidt, Regional Aging Services Program Administrator

Serving: Burleigh, Morton, Kidder, Grant, McLean, Mercer, Sheridan, Sioux, Emmons, & Oliver Counties

Fall 2004

INSIDE THIS ISSUE:



AGING SERVICES NEWSLETTER

Please share this newsletter with a friend, coworker, at your Senior Center, post on a bulletin board, etc… If you wish not to be on the mailing list for the newsletter, please contact **Cherry Schmidt** at **328-8787**. You are welcome to submit any news you may have regarding services and activities that are of interest to seniors in this region. **West Central Human Service Center** makes available all services and assistance without regard to race, color, national origin, religion, age, sex, or handicap, and is subject to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1975 as amended. **West Central Human Service Center** is an equal opportunity employer.

MISSION STATEMENT:

In a leadership role, Aging Services will actively advocate for individual life choices and develop quality services in response to the needs of vulnerable adults, persons with physical disabilities, and an aging society in North Dakota.

north dakota department of human services

Home Food Safety Tips

Out with the Old, In with the New:

'Tis the Season to Ring in New Home Food Safety Traditions

Eat, drink and be merry with these simple home food safety tips from the American Dietetic Association and ConAgra Foods

Reckless Thawing

- **Old Habit**: More than one out of four Americans admit to thawing their frozen turkey or other main meat dish on the kitchen counter, in the oven or even under hot water in the kitchen sink.
- **New Tradition:** To prevent the spread of harmful bacteria, frozen meats should be thawed-and marinated, for that matter in a refrigerator set below 40 degrees Fahrenheit, or sink filled with cold tap water, making sure to change the water every 30 minutes.

Holding Out on Hot Stuff

- **Old Habit:** When preparing a cooked dish that needs to chill (for storage or serving purposes), nearly four out of five home cooks think it's necessary to wait until foods cool before putting them in the refrigerator.
- **New Tradition:** Once upon a time, placing hot foods in the refrigerator could lower the overall temperature of the fridge and cause foods to spoil. Not anymore! To ensure the freshness and safety of your freshly cooked foods, place them promptly in the refrigerator after cooking…no need to wait.

Covered Dish Delivery

- **Old Habit:** Three out of five holiday revelers typically travel for at least one hour with their home made holiday dish to a relative or friend's home.
- **New Tradition:** Pay close attention to how much time passes from the time you leave your door until your dish is eaten. If it's more than two hours, consider packing your cold dish in a cooler or hot dish in an insulated bag to keep it safe and bacteria-free.

Rocking the Gravy Boat

- **Old Habit:** While a majority (71 percent) of home cooks remember to bring gravy to a boil before serving it, many forget the same rule also applies during the encore presentation. In fact, more than half just reheat leftover gravy in the microwave until it's hot before serving again.
- **New Tradition:** In order to eliminate harmful bacteria, always bring leftover gravy to a boil on the stove before serving it a second or even third time around.

Festive Floor-grazing

- **Old Habit:** Nearly one out of four Americans say they abide by a specific "rule" to determine how long food is safe to eat after in falls on the floor, with the majority giving a green light to food rescued within three seconds.
- **New Tradition:** Tragic as it may be when a holiday treat topples to the floor, it's never a good idea to eat it. In the spirit of "out with the old, in with the new," toss it.

Source: ADA/ConAgra Foods Home Safety…It's in your Hands

ND Family Caregiver Support Program

Alzheimer's: Dealing With Repetitive Behavior – How To Reassure Them While Preserving Your Equilibrium

Beth Witrogen McLeod

People with Alzheimer's disease often act as if their minds are caught in an endless tape loop. They may ask the same question 20 times in an afternoon, pace a stretch of floor for hours, or hum a tune that never seems to run out of verses. Many have a condition called echolalia, in which the patient repeats words endlessly or echoes a phrase. If you're caring for someone with the disease, this sort of thing may make you feel like crying or tearing your hair.

It's important to know that your loved one isn't trying to annoy you or push you to the breaking point. A continually repeated question, for instance, doesn't mean that he or she isn't listening to the answer. The 36-Hour Day, an excellent handbook for families coping with Alzheimer's, explains that this repetition may be a sign of the insecurity and uncertainty caused by memory loss. In the later stages of the disease, damage to the memory may be so severe that the sufferer will not even remember asking the question.

Through these words and actions, the person with Alzheimer's may also be expressing a specific concern, asking for help, or coping with frustration in the only way he or she knows. By understanding the reasons behind repetitive behavior, you can help provide comfort while preserving your own sanity.

How to reassure them while preserving your equilibrium:

"Reassurance is an excellent tool to use in managing difficult behavior," says family outreach specialist Jan Oringer of the Family Caregiver Alliance in San Francisco. "Often that behavior is due to anxiety or fear, and you need to be sensitive to your loved one's emotions. Be aware of your touch, tone of voice, not rushing or being too anxious."

If your loved one constantly asks who you are or keeps asking for a long-dead friend or spouse, it may be out of worry that there's nobody to care for him or her. By the same token, repeated questions about the next doctor's appointment may mean that he or she has health concerns or is afraid of the doctor.

Instead of answering such questions every time they're asked, reply with words of comfort. When your loved one wants to know who you are, say in a calm, soothing voice that everything is fine, that you're there and will take care of him. Add that there will be plenty of food tonight, and that he or she is fortunate to have such a great doctor. If words don't help, you may be able to ease his fears by putting on music, giving a shoulder massage, taking a walk outside, or another pleasant diversion.

Your loved one might have other reasons for saying the same things over and over. Some people with dementia may use repetition as a way to keep a conversation going when they know they're not holding up their end, says Dr. William Molloy, a professor of medicine at McMaster University in Hamilton, Ontario, and director of the university's Memory Clinic. Again, a few reassuring words or a little redirection might help.

Sometimes, of course, repeated questions may not stop despite your best efforts. In a memoir about caring for her elderly husband who has Alzheimer's, Lela Knox Shanks recalls, "In the beginning, when Hughes asked the same thing over and over again, I wanted to scream and sometimes did -- but that was not a satisfactory solution. I learned…to write notes to Hughes during that stressful period. Since he asked the same questions every day, I accumulated a set of stock answers that I flashed to his questions. By keeping silent I was better able to remain calm, [and] Hughes never questioned why I was communicating with him through signs."

Other forms of repetitive behavior are often just as frustrating as nonstop questions. Indeed, it can be heart-wrenching to see a formerly gifted, accomplished person spend the afternoon pacing the kitchen or folding the same towel. He or she may even walk into a corner, and, unable to turn around, keep marching in place. But with gentle reassurance and guidance, you can help break this pattern of behavior.

Instead of saying, "Quit walking around the kitchen," you might ask if he or she would like to sit down and look at pictures in the living room. Or you might also suggest that the two of you walk outdoors. But – very important – you should also ask yourself if the behavior really needs to be stopped. Your loved one may feel competent and helpful when he or she is folding that towel 50 times, and the towel won't mind, either.

Here are other strategies from the Alzheimer's Association and Family Caregiver Alliance to help you cope with repetitive behavior:

- Look for patterns. Keep a log to determine if the behavior occurs at a certain time of day or night, or whether particular people or events seem to trigger it.
- Keep track so you can tell whether your loved one might be hungry, cold, tired, in pain, or in need of a trip to the bathroom.
- Check with the doctor to make sure your loved one isn't suffering from pain or the side effects of medication.
- Speak slowly and wait for your loved one to respond.
- Don't point out that he or she just asked the same question.
- Distract him or her with a favorite activity.
- Use signs, notes, and calendars to help decrease anxiety and uncertainty. In the early stages of Alzheiemer's, when your loved one can still read, he or she may not need to ask about dinner if a note on the table says, "Dinner is at 6:30 p.m."

Talking with friends, a counselor, or a support group about your grief and frustration at the damage caused by Alzheimer's also leave you free to cope with its reality and to cherish hour loved one as he or she is. "So many times we talk about caregiving in a somewhat negative fashion," says Oringer, of the Family Caregiver Alliance. "But I see a lot of families where this has been an opportunity to grow, and to find more adaptive ways of solving difficulties. These aren't just caregiver skills, but life skills all of us need."

Beth Witrogen Mcleod

Beth Witrogen Mcleod is an author, journalist, speaker and consultant on caregiving, end-of-life issues and renewal at midlife, especially for women. She is a double Pulitzer Prize nominee, and has won many national and regional awards for her work. She has written for Good Housekeeping, SELF, Family Circle, and the Wall Street Journal, among others. Her latest book is Caregiving: The Spiritual Journey of Love, Loss, and Renewal.

Her expertise grew out of personal experience caring for her parents who were simultaneously terminally ill 1,200 miles away. With a father dying from a rare form of cancer and a mother with Lou Gehrig's disease and dementia, McLeod learned firsthand about the traumas and blessings of this mid-life rite of passage. She turned her experiences into a passion for public service, first writing and producing an award –winning newspaper series, "The Caregivers," for The San Francisco Examiner in 1995. It was nominated for a Pulitzer Prize. She developed a weekly column for The Examiner that often appeared on the New York Times Syndicate Web site. Honors for the series included National Hospice Organization, Pew Charitable Trusts, American Legion Auxiliary, Society of Professional Journalists and many regional and local social service organizations.

 This article originally appeared on www.thirdage.com. For more information, please contact the author through www.witrogen.com.

HHS Awards $6.78 Million to Expand Alzheimer's Disease Demonstration Programs

HHS Secretary Tommy G. Thompson announced on Thursday $6.78 million to develop innovative approaches to provide care for people with Alzheimer's disease and support for their family caregivers.

The Alzheimer's Disease Demonstration Grants to States (ADDGS) Program works to improve the responsiveness of home and community-based services to persons with dementia and their caregivers.

"The pain of losing a loved one to Alzheimer's disease is too often compounded by not being able to care for them," Secretary Thompson said. "This funding will give thousands of families the opportunity to provide the support, compassion, and love that only a family member could."

The awards will support one-year capacity building demonstration programs in two new states: South Dakota and Wyoming. The awards will further support three-year systems change demonstration programs in 22 states/territories: Alabama, Arizona, Arkansas, California, Delaware, the District of Columbia, Florida, Indiana, Iowa, Louisiana, Maine, Minnesota, Missouri, Nevada, New Mexico, North Carolina, **North Dakota,** Rhode Island, Tennessee, Vermont, Virginia, and Wisconsin.

The Program is administered by HHS' Administration on Aging (AoA). It focuses on serving hard-to-reach and underserved people with Alzheimer's disease or related disorders.

For additional information about the ADDGS grants, continuing grants, other information about Alzheimer's disease and tips for families affected by Alzheimer's Disease are available at http://www.aoa.gov/alz.

New Rules Proposed to Deliver Better Benefits and Savings on Drugs for Medicare Beneficiaries

Proposed regulations, posted for public comment, would implement the Medicare Modernization Act that creates a new voluntary prescription drug benefit under Medicare, as well as new health plan choices.

The full prescription drug benefit begins Jan. 1, 2006. It will allow all Medicare beneficiaries to enroll in drug coverage through a prescription drug plan or Medicare health plan. The new Medicare benefits are voluntary; seniors can choose to keep their existing traditional coverage.

The prescription drug benefit is a key element of the Medicare Modernization Act. The Centers for Medicare & Medicaid Services (CMS) has also proposed rules to implement another key element of the law: strengthening and improving the Medicare Advantage program, including making regional preferred provider organizations (PPOs) available to all Medicare beneficiaries. The proposed rules would also implement new, less costly options for Medigap coverage.

The new prescription drug benefit will help Medicare beneficiaries lower the prices they currently pay for prescription drugs and provide more choices and greater access to high quality care. When the regulations are implemented, beneficiaries who wish to receive the prescription drug benefit can choose to enroll either in a Medicare health plan or a prescription drug plan with a monthly premium of about $35. The drug coverage will be available to enrollees who choose the traditional, fee-for-service Medicare plan as well as any Medicare Advantage program.

Under the prescription drug plan, all beneficiaries regardless of income will receive help with their drug bills. After first paying the $250 deductible, the beneficiary will pay 25% of drug costs up to $2,250, then 100% of the drug costs until spending a total of $3,600 out-of-pocket costs (or $5,100 total in drug costs), then only 5% of drug costs after that. There is no annual plan maximum. On average, the new benefit will cover about half of prescription drug costs for those currently without coverage.

Low-income “dual-eligible” beneficiaries will have no premium or deductible and co-payments of as little as $1 or $3 per prescription. Medicare will pay, on average, 97% of their drug costs. Medicare beneficiaries who are not full benefit dual eligibles with incomes less than 135% of the federal poverty level and limited assets will also pay only a few dollars per prescription. Medicare will cover 95% of their drug costs on average. Beneficiaries with incomes below 150% of the federal poverty level and assets up to $10,000 ($20,000 if married) in 2006, will have 15% co-payments with a sliding-scale premium. Medicare will cover, on average 85%, of their drug costs.

The proposed rules make clear that the asset test will only count liquid assets and real estate holdings other than a beneficiary’s home or residential farm.

Non-liquid assets like wedding rings, family heirlooms, and burial plots will not be counted. The rule outlines methods to collaborate with Social Security, states and non-governmental organizations that work with Medicare beneficiaries with limited means to enroll as many eligible beneficiaries as possible. About a third of all Medicare beneficiaries will qualify for these very comprehensive benefits.

The new rule gives employers options to continue subsidizing drug coverage for their retirees. The options are important to help assure that these retirees are better off than they are now. Employers may offer "wraparound" coverage, similar to the wraparound coverage they provide for Part A and Part B Medicare benefits.

Beneficiaries choosing to enroll in a Medicare Advantage program can get drug benefits as part of their plan.

The new rules provide support for regional Medicare Advantage preferred provider organizations as an option for Medicare beneficiaries beginning on Jan. 1, 2006. These changes are important options for Medicare beneficiaries without good, inexpensive supplemental coverage (for example, from Medicaid or an employer) to get extra benefits and lower out-of-pocket costs compared to the traditional fee-for-service Medicare plan. Studies indicate that beneficiaries in Medicare Advantage programs pay about $700 less on average in out-of-pocket medical costs per year. Beneficiaries in fair or poor health may pay about $1,900 less. When the new rules and payments are implemented, PPOs and other coverage options will be more widely available to Medicare beneficiaries.

PPOs are popular health insurance choices for non-Medicare beneficiaries, including millions of Americans in rural areas, in part because they offer both low co-payments for "network" services as well as coverage for non-"network" care from any provider. Under the proposed rules new regional PPOs will bid to serve an entire region. Following public input and analysis, the Secretary of Health and Human Services will establish 10 to 50 Medicare Advantage regions.

Under the proposed rules, all of these plans must offer the same benefits as traditional fee-for-service Medicare with simplified cost-sharing and new protection against catastrophic costs. They are also expected to offer additional benefits not available in fee-for-service Medicare, such as dental or vision services; lower co-payments or other reduced cost sharing; payment of a beneficiary's premium for these supplemental benefits; or lower Medicare Part B premiums and drug benefit premiums.

The rule supports creation of plans to offer health care services to people with special needs, such as those who are Medicaid eligible, have severe or disabling chronic conditions, or live in nursing homes or other long-term care institutions.

More information on the rule is available at *www.cms.hhs.gov/medicarereform*.

(Article submitted by Bill Lardy, Senior Health Insurance Counseling/Prescription Connection for ND and is based on information available as of September 17, 2004)

Medicare Fraud Costs All of Us $13 Billion a Year!

You Can Help Stop Medicare Fraud

If you suspect Medicare Fraud,

Call Legal Services of North Dakota

1-800-634-5263

What might make you suspect fraud?

<u>The provider tells you</u>:

- The test is free; they only need your Medicare numbers for their records
- Medicare wants you to have the item or service
- They know how to get Medicare to pay for it
- The more tests they provide the cheaper they are
- The equipment or service is free; it won't cost you anything

Caution: Your Medicare Number needs to be protected as carefully as you would a credit card number

"The above information is from the Office of Inspector General-2002"

North Dakota "2-1-1" Get Connected. Get Answers

Every hour of every day, someone needs essential services – emergency food and financial assistance, affordable mental health services or suicide intervention. In many cases, people end up going without these necessary and readily available services because they do not know where to start.

All that has changed for many North Dakota residents. Instead of searching through the often-confusing maze of available services, people can now dial "2-1-1," a universally recognizable number that makes a critical connection between callers and the appropriate community-based organizations and government agencies. "2-1-1 offers obvious advantages for people in need," said Governor John Hoeven when the pilot project was launched in the Bismarck/Mandan area on February 11, 2004. "It's easy to get help. If you need emergency shelter or help escaping an abusive relationship, knowing these three simple numbers can be the key to getting the assistance you need and getting back on your feet."

"2-1-1 is a great example of how a partnership between government, non-profit organizations and the private sector can assist our citizens. With one easy-to-remember number, people can find information about a multitude of services and agencies, or receive instant help in a crisis," said Attorney General Wayne Stenehjem.

But 2-1-1 is for everyone, not just people and communities in crisis. You can use it any time. If you're new to the area and are trying to locate employment services, day care, transportation, etc., 2-1-1 can connect you. In these days of terrorism alerts, it's important to think of 2-1-1 as a crisis response tool for the entire community, as well. 2-1-1 can be integral to the community's response to a widespread crisis like an attack, flood, tornado, fire or other tragedy. Businesses, such as hotels, hospitals, etc., that have specialized internal telephone systems may need to reprogram their equipment so that their employees and clients are able to use the 2-1-1 service.

Since the initial launch in February, additional territory has been gradually included into the service area. On August 1, 2004, the final implementation phase was completed and the program became available statewide. "We had heard from 2-1-1 providers in other parts of the country that one of the biggest challenges in getting their programs up & running was working with the telecommunications companies. Here in North Dakota, we found the telecommunication providers wonderful to work with – they understood what had to be done, why it had to be done, and simply did it." Cellular customers, Minnesota residents and others who may not be able to use 2-1-1 (some internal telephone systems may require programming changes) can continue to receive crisis intervention, information and referral services through the toll-free HELP-LINE. That number is 800-472-2911.

The 2-1-1 dialing code was assigned by the FCC for health and human service information and referral in July of 2000. To date, approximately 32% of Americans have access to 2-1-1, thanks to the efforts of the Alliance of Information and Referral Systems (AIRS) and the United Way of America. Bipartisan federal legislation has also recently been introduced that would provide for $200 million in funding for 2-1-1 programs nationwide.

The Mental Health Association in North Dakota has been providing the HELP-LINE service for over 33 years. In September of 2003, they were awarded the official designation by the North Dakota Public Service Commission to provide 2-1-1 services statewide. The United Way agencies throughout North Dakota have been very supportive of the efforts of the Mental Health Association in North Dakota in the implementation of the 2-1-1 programs, both financially and collaboratively. Their support has been invaluable in helping to organize stakeholders, addressing their issues and ensuring a smooth transition to an efficient and professional statewide 2-1-1 service.

For more information contact:
Deanna Dailey, CIRS
ND 2-1-1/HELP-LINE Program Administrator
PO Box 4106 Bismarck, ND 58502-4106
(701) 255-3692, Ext. 111

North Dakota 2-1-1 Get Connected. Get Answers.

(Article submitted by Deanna Dailey, Mental Health Association of ND)

Governor's Forums on Aging: Focus on Home and Community Based Services

North Dakota is "out of balance", according to policy expert on aging services, Susan Reinhard, who recently spoke at the Western ND Governor's Forums on Aging held September 20-23, 2004 in Bismarck, Minot, Dickinson, and Williston.

Dr. Reinhard, co-director of Rutgers Center for State Health Policy and deputy commissioner of the New Jersey Department of Health and Senior Services, said North Dakota's long-term care strategies rely too heavily on nursing homes.

North Dakota spends about 10 percent of state and federal dollars on home and community-based services, she said. This compares with a national average of 30 percent.

"States that are very progressive, like Oregon, spend about 50 percent on home care and 50 percent on nursing-home care," Reinhard said. "You have a heavy reliance on nursing homes. You spend a lot. It's used a lot. You keep your occupancy fairly high, and you would have to ask 'why?' when the rest of the country's occupancy is dropping."

North Dakota spends 33 percent of its Medicaid budget on nursing-home care, Reinhard added. The country's average is 22 percent.

A statewide survey showed 83 percent of North Dakotans want to be at home as long as possible, while only 5 percent listed nursing homes as a desired option for themselves.

"So 90 percent of your money is going to nursing homes, and only 5 percent of you want to be there," Reinhard said.

The state has made progressive moves, though, she said. Spending money to buy out 700 nursing home beds across the state was a unique move, she said. She also cited the state's participation in a program that uses federal funding to pay for respite care, even when family members provide the care. Respite care gives regular family caregivers a break.

Reinhard promoted the concept of global budgeting-creating a single pool of money for long-term care and being flexible in dividing it among the services people need. She also encouraged the use of adult family homes, or adult foster homes, and adult day centers.

Reinhard said the state needs to pay more to support nursing-home alternatives a comment that drew some audience feedback.

One service provider said it's difficult to convince legislators to shift funding when nursing home administrators are pleading to keep jobs in the community.

Reinhard said nursing homes need to re-invent themselves to provide home-and community-based services.

"The people who are doing those services can be home-care workers. There's no reason they have to be working in those institutions," she said.

(The above article was adapted from the Minot Daily News 9/24/04)

Approximately 141 people attended the Bismarck Forum on September 20th at the Bismarck Senior Center. For more information about the topics discussed at the Forum or information on Long-Term Care services or Services in the Community for older adults contact the ND Senior Info-Line at 1-800-451-8693 or Cherry Schmidt, RASPA, at 701-328-8787/1-888-328-2662.

Telephone Numbers to Know

Regional Aging Services Program Administrators

Region I - Karen Quick
1-800-231-7724
Region II - MariDon Sorum
1-888-470-6968
Region III - Donna Olson
1-888-607-8610
Region IV - Patricia Soli
1-888-256-6742
Region V - Sandy Arends
1-888-342-4900
Region VI - Russ Sunderland
1-800-260-1310
Region VII - Cherry Schmidt
1-888-328-2662
Region VIII - Mark Jesser
1-888-227-7525

Vulnerable Adult Protective Services

Region I & II – Niels Anderson, Vulnerable Adult Protective Services, Long Term Care Ombudsman - 1-888-470-6968

Region III – Ava Boknecht, Vulnerable Adult Protective Services, 1-888-607-8610

Region IV - Adult Protective Services - Vulnerable Adult Phone Message Line 701-795-3176

Region V - Vulnerable Adult Protective Services, Sandy Arends - 1-888-342-4900. Direct referral may be made to Cass County Adult Protective Services unit - 701-241-5747.

Region VI - Russ Sunderland, Vulnerable Adult Protective Services - 701-253-6344

Region VII - Cherry Schmidt, Vulnerable Adult Protective Services - 1-888-328-2662

Region VIII - Mark Jesser, Vulnerable Adult Protective Services & Long Term Care Ombudsman - 1-888-227-7525

ND Family Caregiver Coordinators

Region I - Karen Quick - 800-231-7724
Region II – Lester Hill - 888-470-6968
Region III - Kim Locker-Helten - 888-607-8610
Region IV - Raeann Johnson - 888-256-6742
Region V - Lesli Ossenfort - 888-342-4900
Region VI-CarrieThompson-Widmer -800-260-1310
Region VII - Judy Tschider - 888-328-2662
Region VIII - Michelle Sletvold- 888-227-7525

Other

Aging Services Division Office, Long-term Care Ombudsman and Senior Info Line: **1-800-451-8693**

AARP: **1-888-OUR-AARP (1-888-687-2277)**

AARP Pharmacy: **1-800-456-2277**

ND Mental Health Association (Local) **701-255-3692/** Help-Line: **1-800-472-2911**

IPAT (Interagency Program for Assistive Technology): **1-800-265-4728**

Legal Services of North Dakota:
1-800-634-5263 or
1-866-621-9886 (for persons aged 60+)

Attorney General's Office of Consumer Protection: **(701) 328-3404** or **1-800-472-2600**

Social Security Administration: **1-800-772-1213**

Medicare: **1-800-247-2267**/**1-800-MEDICARE**

Toll-Free 800 Information: (Directory Assistance for 800 number listings): **1-800-555-1212**

Senior Health Insurance Counseling (SHIC) ND Insurance Department : **(701) 328-2440**

Prescription Connection: **1-888-575-6611**

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